APPLICATION FOR APPROVAL OF PROFESSIONAL SUPERVISION FOR CONTINUING EDUCATION CREDIT

State Form 50256 (7-01)
Approved by State Board of Accounts, 2001

* Disclosure of your Social Security number is MANDATORY according to IC 4-1-8-1 and this application cannot be processed without it.

RETURN THIS APPLICATION TO:
INDIANA STATE PSYCHOLOGY BOARD
HEALTH PROFESSIONS BUREAU
402 West Washington Street, Room 041
Indianapolis, IN 46204
www.in.gov/hpb

Date viewed	Decision	Initials

DO NOT WRITE ABOVE THIS BOX

THIS FORM IS TO BE USED BY LICENSED PSYCHOLOGISTS WHO ARE APPLYING FOR APPROVAL OF PROFESSIONAL SUPERVISION FOR CATEGORY II CONTINUING EDUCATION CREDIT. ONLY INDIVIDUAL FACE-TO-FACE SUPERVISION MAY BE CLAIMED FOR CREDIT. A MAXIMUM OF TEN HOURS OF CREDIT MAY BE EARNED FOR PROFESSIONAL SUPERVISION IN EACH TWO YEAR LICENSE PERIOD. ONLY PERSONS RECEIVING SUPERVISION MAY EARN CREDITS.

Name of applicant		License number
Address (*number and street, city, state, ZIP code*)		
Telephone number (*daytime*)	E-mail address	Social Security number *

Name of supervisor
Is supervisor licensed to practice psychology in Indiana? ☐ Yes ☐ No
If no, please describe the credentials of your supervisor:

Location of supervision: Name of facility
Address (*number and street, city, state, ZIP code*)

Nature of supervision (*what functions did you perform under supervision*)?

(*Continued on the reverse side.*)

Beginning and ending dates of supervision:	
Number of hours of supervision (*individual face-to-face supervision only*)	Number of credit hours claimed

APPLICATION AFFIRMATION	
I hereby swear or affirm under the penalties of perjury that the statements made in this application are true, complete, and correct.	
Signature of applicant	Date signed (*month, day, year*)

AUTHORIZATION FOR RELEASE OF INFORMATION

I hereby authorize and direct any person, firm, officer, corporation, association, organization, or institution to release to the Health Professions Bureau of Indiana, or the Indiana State Psychology Board, any files, documents, records, or other information pertaining to the named applicant requested by the Bureau or the Board or any of their authorized representatives, in connection with processing this application for approval of professional supervision.

I hereby release the aforementioned persons, firms, corporations, associations, organizations, and institutions from any liability with regard to such inspection or furnishing of any such information.

I further authorize the Health Professions Bureau of Indiana or the Indiana State Psychology Board to disclose to the aforementioned organizations, persons, and institutions any information which is material to any application, and I hereby specifically release the Bureau, and the Board, from any and all liability in connection with such disclosures.

A photostatic copy of this authorization has the same force and effect as the original.

AFFIRMATION

I hereby swear or affirm that I have read the above statements and agree to same.

Signature of applicant	Date signed (*month, day, year*)

NOTICE

* In compliance with IC 4-1-6, this agency is notifying you that you must provide the requested information or your application will not be processed. You have the right to challenge, correct, or explain the information maintained by this agency. The information you provide will become public record.